MetroHealth

August 29, 2019

Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

RE: WC Docket No. 18-213 – Promoting Telehealth for Low-Income Consumers (FCC Connected Care Pilot Program)

Dear Commission:

On behalf of The MetroHealth System in Cleveland, Ohio, I am submitting comments on the Federal Communications Commission's (FCC) request for comments on the proposed Connected Care Pilot Program.

The MetroHealth System a large, public safety net provider located in Cuyahoga County, Ohio, which includes the City of Cleveland and its surrounding suburbs. MetroHealth is committed to improving the health of the community and reducing health disparities and health inequities. Our staff of 8,000 provides care at MetroHealth's four hospitals, four emergency departments, and more than 20 health centers and 40 additional sites throughout Cuyahoga County. The health system is also home to Cuyahoga County's most experienced Level I Adult Trauma Center, verified since 1992, and Ohio's only adult and pediatric trauma and burn center. In 2018, MetroHealth has served 300,000 patients at more than 1.4 million visits in its hospitals and health centers, 75 percent of whom are uninsured or covered by Medicare or Medicaid. The community served by MetroHealth experiences several health disparities including: health outcomes related to chronic conditions like diabetes, heart disease, and asthma; barriers to accessing care, especially transportation, broadband Internet access, and health insurance; social determinants of health like poverty, unemployment, and housing instability; and the pressing issues of opioids, care for older adults, and community trauma.

MetroHealth strives to partner with providers in rural regions of Northeast Ohio and beyond to ensure access to high quality care for the communities that we serve. To that end, we recently partnered with eight joint township district and county hospitals – all rural or critical access in status – to identify opportunities for shared learning and mutual advocacy. In addition, we partnered with another rural hospital to create a level III trauma center. In our experience, we have found that urban and rural providers can have symbiotic roles, especially as it pertains to telehealth. We believe there are significant opportunities under this and future programs to better align the work of urban and rural systems and providers.

The issues facing the community we serve closely align with the goals of the proposed Connected Care Pilot, and we applaud the FCC's efforts to bring telehealth services directly to low-income patients via the Connected Care Pilot Program. We thank the FCC for the opportunity to provide comments on this Notice of Proposed Rulemaking (NPRM) outlining the Pilot program; our specific comments are below.

Budget (section 19): We recommend that the FCC allow flexibility for applicants in how they propose to receive funding distributions over the three-year period, and we encourage the FCC to allow additional flexibility in how funding can be used under the program. This flexibility would

enable applicants to tailor the use of and access to program funds in accordance with their unique project timelines and cadence. Additionally, we recommend that the FCC provide funds based on the needs identified in each selected project application, rather than make uniform award amounts across all selected applicants, understanding that providing access to broadband internet services only solves part of the issue – patients must be able to afford to use these services associated with access to broadband in an ongoing fashion. This would allow the FCC to maximize its use of funds across projects to meet specific community needs.

Project Period (number 27): We are supportive of the FCC's recognition that it will take time for selected applicants to prepare for program implementation, given the procurement and contracting that will be required under the program. While we agree that a wind-up period is essential to successful implementation, we do not believe that a wind-down period is critical. Therefore, we recommend that the FCC extend the wind-up period to up to 12 months, with the option for selected applicants to begin their three-year period at any time during the 12-month wind-up period, based on when they complete their pre-implementation activities.

Geographic Diversity (number 34): There is tremendous value in supporting broadband connectivity in medically underserved urban areas. However, limiting participation to health professional shortage area (HPSA) or medically underserved area (MUA) designation may artificially limit the impact of the program in other areas that stand to benefit from improved access to connected care services. In addition to these designations, we strongly encourage the FCC to broaden the geographic requirements to also allow for participation of eligible health care providers that serve a population that is greater than two thirds Medicare, Medicaid, and/or uninsured patients. This can easily be verified utilizing the most recently filed Medicare cost report.

Federal Designation of Providers (number 36): The goals of the program are to expand broadband connectivity for connected care services. We do not believe that the FCC should limit eligibility in the Pilot program solely to health care providers that are federally designated as Telehealth Resource Centers or Telehealth Centers of Excellence. Consolidating scarce federal resources to providers that already have a rich experience in telehealth, as demonstrated by their federal designation status, may further stymie communities lacking the resources to invest in the services available through this Pilot program. By not limiting eligibility to a small pool of advanced entities, the FCC will be able to invest in a more diverse landscape of low-income communities in need of broadband services to support connected care.

Application Evaluation Criteria (number 48): We strongly encourage the FCC not to adopt an urban v. rural approach to application scoring, as the Pilot program can and should be an opportunity to address the issue of broadband access which is a concern to low-income communities generally, regardless of their urban or rural status. Low-income, vulnerable populations in urban areas experience similar challenges related to connectivity gaps and in accessing necessary health care as the FCC has identified for rural areas, even if these challenges manifest differently in an urban environment.

Recent telehealth legislation and program efforts have focused on overcoming the challenges geography places on rural patients' ability to receive timely access to needed health care services. In urban settings, geography is a factor not necessarily due to distance, but more so

due to the living environment and/or other barriers urban patients face that limit their ability to access health care services. There has been notable success leveraging telehealth services in rural populations, and we believe that urban populations can equally benefit from access to telehealth services.

We propose the FCC eliminate scoring that favors rural applicants and instead consider urban and rural applicants equally, focusing scoring instead on the population served and the barriers to be addressed in the proposal. Our position is that the proposed weighted scoring based on geography creates unnecessary barriers for urban, underserved applicants, and contributes to further disparities in access to care. Whether the patient must travel 50 miles by car or two hours via public transit to the nearest care site, access to care is a priority issue of urban and rural providers alike.

Additionally, there are opportunities for urban and rural providers to collaborate in meeting the access and care needs of their respective populations, and we urge the FCC to foster a collaborative rather than competitive environment among these providers. As health care provider organizations continue to transform patient care delivery to improve access, we strongly support a care model that leverages telehealth services across the entire care continuum without any geographic limitations or designations.

We have identified several articles that support our position. An article in *Health Affairs* points out that "while geography is an important aspect of access to health care, it fails to accurately capture the relationship between supply (providers) and demand (patients) within an area." [i] The authors further explain, "the best way to care for patients in rural environments is to build programs that synchronize rural and urban care," and also add, "aligning payment structures to focus on the availability of timely care instead of historic geographic constructs is essential." Additional articles from the telehealth industry further support this position.[ii,iii]

In closing, we thank the FCC for the opportunity to comment on the Connected Care Pilot Program and look forward to future announcements and opportunities regarding the program.

Sincerely,

Michael Dalton

Vice President, Executive Projects

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[i] Huilgol, Y.S., Joshi, A., Carr, B.G., & Hollander, J., (2017). Health Affairs, *Giving Urban Health Care Access Issues the Attention They Deserve in Telemedicine Reimbursement*. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20171022.713615/full/

[ii] CTEL News, (2017), CTEL, *Telehealth in Urban Areas? Health Affairs Op-Ed Highlights Need.* Retrieved from https://ctel.org/2017/10/telehealth-in-urban-areas-health-affairs-op-ed-highlights-need/

[iii] Wagenen, J.V., (2018), HealthTech, *Telehealth Plays a Key Role in Improving Urban Pediatric, Neonatal Care.* Retrieved from https://healthtechmagazine.net/article/2018/02/telehealth-plays-key-role-improving-urban-pediatric-neonatal-care